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ABSTRACT

This report summarizes findings of a World Health Organization meeting on the topic of training drug treatment center personnel about Acquired Immune Deficiency Syndrome (AIDS). The first section discusses issues surrounding AIDS and drug abusers. Prevalence rates for intravenous drug abusers in various European countries are discussed. Prevention and treatment efforts in Denmark, Norway, France, England, Scotland, and Switzerland are discussed. Staff responses in drug treatment programs dealing with patients with AIDS are described. It is recommended that national and regional agencies consider hiring additional treatment staff to serve the increasing number of clients entering treatment. The second section describes development of training guidelines. Nine components of a training plan are listed. Training guidelines are presented in the following areas: (1) an appropriate and accurate assessment of the need for training; (2) targeting all drug treatment personnel for AIDS training; (3) including a planning committee at the national level; and (4) selecting effective trainers. It is recommended that the curriculum should have three interconnected and interactive parts dealing with facts, such as the transmission of human immune virus and risk reduction; attitudes, including work with staff to relieve their fears about AIDS; and the development of skills such as the ability to impart specific knowledge about AIDS to clients. Eleven specific content areas are described. Issues involved in implementation are discussed, including time commitment, and techniques to be used. (ABL)

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Training on AIDS for personnel in drug treatment centres

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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this Organization, which was created in 1948, the health professions of some 160 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region has 32 active Member States,[a] and is unique in that a large proportion of them are industrialized countries with highly advanced medical services. The European programme therefore differs from those of other regions in concentrating on the problems associated with industrial society. In its strategy for attaining the goal of "health for all by the year 2000" the Regional Office is arranging its activities in three main areas: promotion of lifestyles conducive to health; reduction of preventable conditions; and provision of care that is adequate, accessible and acceptable to all.

The Region is also characterized by the large number of languages spoken by its peoples, and the resulting difficulties in disseminating information to all who may need it. The Regional Office publishes in four languages — English, French, German and Russian — and applications for rights of translation into other languages are most welcome.

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Training on AIDS for personnel in drug treatment centres

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Report on a WHO meeting

Bremen
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Introduction

At the Consultation on AIDS among Drug Abusers, held in Stockholm in October 1986, experts from 12 European countries, Canada and the United States of America strongly suggested that the staff of drug treatment centres be prepared to deal with the crisis caused by the acquired immunodeficiency syndrome (AIDS). In fact, drug treatment programmes were seen as the first line of defence in the prevention of the disease among intravenous drug abusers, whether in treatment or not, and their sexual partners.

It has been recognized that the staff of drug treatment programmes are the people most familiar with the psychological and physical issues of chemical dependency and can communicate best with this alienated population. The participants at the Consultation acknowledged that drug treatment staff needed training in the use of specific techniques of education and counselling on infection with human immunodeficiency virus (HIV) and the psychosocial and physical consequences of AIDS. Further, the participants suggested that a special meeting of experts on training and education within the WHO European Region be convened to recommend guidelines for such training.

As a result, the Meeting on Training on AIDS for Personnel in Drug Treatment Centres was held in Bremen, Federal Republic of Germany in August 1987, and attended by participants from 17 European countries and the United States. The meeting was hosted and supported by the city of Bremen and the Ministry for Youth, Family Affairs, Women and Health. The participants are listed in Annex 1. These experts met:

— to develop guidelines on AIDS training for drug treatment staff

— to examine existing training programmes

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— to suggest models for organizing, developing and implementing such programmes.

The papers presented provided background information on the spread of HIV infection and AIDS among drug abusers and on the clinical and psychological effects of HIV infection and AIDS. Participants reviewed the status and activities of current training programmes in five countries. The participants formed working groups to discuss various training issues and recommend guidelines.

AIDS and drug abusers: current issues

The Situation in Europe

AIDS first appeared among intravenous drug abusers in Europe in 1984, three years after the first cases were seen among homosexual men. The epidemic has spread more rapidly among intravenous drug users than in any other risk group. By June 1987, 28 European countries had reported 6881 cases of AIDS; 1123 of these were found in heterosexual drug addicts and 171 in homosexual male drug addicts. The proportion of heterosexual intravenous drug abusers in the population of AIDS victims has increased dramatically, from 1% in December 1984 to 7% in December 1985, 14% in December 1986 and 16% in June 1987.

In Europe three countries — France, Italy and Spain — account for 85% of the total number of cases of AIDS in intravenous drug abusers in Europe. In these countries, serological surveys, often small-scale, have revealed prevalence rates of HIV infection of nearly 70% in intravenous drug abusers, although large regional variations can be observed. In Italy the overall prevalence is 37.3%, but rates are as high as 61.4% in Sardinia, 60% in the metropolitan area of Milan and 54.9% in Lombardy. Estimated prevalence rates of HIV infection in other countries or regions are: 20–80% in France (depending on the region), 8% in the Netherlands (34% in Amsterdam), 5–10% in Norway, 58% in Scotland, and 8% in England, Wales and Northern Ireland.

Considering the contrast between the small number of identified cases of AIDS in intravenous drug abusers and the high rates of HIV seroprevalence, it is anticipated that HIV-infected drug abusers will soon place a heavy burden on both drug treatment facilities and specialized health care units.

It should be noted that drug abusers with AIDS differ from other groups with the disease. For example, 92% of intravenous drug

abusers with AIDS present with opportunistic infections, in comparison with 66% for other AIDS patients. This entails longer and more expensive stays in hospital. Further, 72% of drug abusers with AIDS present at less than 30 years of age, while 74% of other AIDS patients are over 30 years.

Efforts at Prevention and Treatment

In their discussions, the participants highlighted some of the issues in needle exchange programmes, in the provision of syringes and in the administration of zidovudine (also called azidothymidine or AZT) to drug abusers.

Participants from countries with needle exchange programmes discussed some problems with implementation that have arisen. For example, because the needle exchange in Amsterdam is not open at night, a night-time black market has sprung up. In Norway needles can only be obtained until midnight. In Bremen machines are used so that needles can be obtained any time of day.

Studies among detained drug users in the Paris region have shown a prevalence of HIV seropositivity of 60–70%. At present efforts are being made to provide medical, social and educational assistance to detained addicts through establishing special teams (*antennes spécialisées pour les toxicomanes*) in the prisons. These teams comprise physicians, nurses, social workers and educators. They concentrate on giving education, information and social support to addicts during imprisonment and in preparation for their release.

Since May 1987 people have been able to buy syringes at pharmacies in France without a medical prescription. This measure was taken for an experimental period of one year. During that period the impact of the measure on the addict population was to be evaluated. In particular, answers to the following questions were to be sought. How smoothly did this measure work? In particular, were pharmacists reluctant to provide syringes to addicts? Did any refuse to do so? Were addicts aware of this liberalization in the sale of syringes? Did they stop sharing needles? Did the measure have any negative effects? More specifically, did it encourage people to abuse drugs by injection?

In England and Scotland the government has set up 15 experimental needle and syringe exchange programmes. All are under evaluation, although the sites and methods of operation vary. Even before the initial evaluation report was due, in December 1987, some programmes were already more attractive than others to drug abusers. In addition, addicts can buy needles and syringes from pharmacies.

In the discussions on zidovudine, there was some concern that the drug may not be made as readily available to drug abusers as it is to

other kinds of AIDS patient, since drug abusers are considered unreliable, unable to follow a complex medication regimen, and more difficult to follow up medically. French participants stated that they had no problems with the medical regimen or follow-up. In France zidovudine is used in people with AIDS or AIDS-related complex (ARC). Patients were usually found to stay with the regimen. Under the conditions for zidovudine administration set up in Sweden, only drug abusers with AIDS could be included, provided that they stopped injecting drugs. In Switzerland, zidovudine may be given to drug abusers on methadone, but not to those who are not in treatment.

Stages of Response in Drug Treatment Programmes

Dr Don Des Jarlais[a] recognized four stages of response to AIDS from drug treatment programmes in New York City:

— denial

— panic

— coping

— burnout.

These stages are applicable to drug treatment programmes elsewhere in the United States and in Europe. A programme administrator should determine the stage that the programme is in when planning training.

In the denial stage, staff try to carry on with business as usual: the treatment of drug abuse. AIDS is seen as a special medical problem that does not need to be integrated into the everyday functioning of the programme. At this stage, staff may resist a training programme or feel that it is not essential to their work. This does not mean, however, that staff should not be trained at this stage. It is important for administrators to plan ahead and communicate the importance of training to staff.

The second stage, panic, usually occurs when the programme confronts the first client who is infected with HIV, who has ARC or AIDS or has a sexual partner or relative with one of these conditions. Now it is impossible to continue normal operations; staff are compelled to do something. Realistic and unrealistic fears about AIDS emerge in the staff, and they search for information on transmission and other medical aspects of AIDS. At this stage, links need to be made

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[a] **Des Jarlais, D.C.** Stages in the response of the drug abuse treatment system to the AIDS epidemic in New York City. *Journal of drug issues* (in press).

with other community agencies providing care for the programme's clients. Staff look to the agency administrating the programme for guidance during this phase. Administrators of drug treatment programmes located in areas where there is a high HIV seroprevalence rate for drug abusers may wish to avoid the panic stage by planning for contingencies and providing training programmes for both staff and clients.

The coping stage involves incorporating AIDS issues into the day-to-day operation of the treatment programme. This requires training for staff on the psychosocial and medical aspects of AIDS, client education and the provision of treatment services for infected clients. This stage may also involve the expansion of the availability of treatment for drug abusers, the incorporation of AIDS prevention programming, the development of innovative programming and links with the community, and changes in policy and guidelines.

In the fourth stage, administrators in programmes with a high number of clients with HIV infection, ARC or AIDS must be aware of the potential for staff burnout. Drug treatment programmes are usually understaffed under normal circumstances; personnel are often overworked and frustrated by dealing with the problems of chemical dependency. Now they must add to this load the medical and psychosocial problems of AIDS. This new responsibility may place an intolerable burden on the staff. In many cases programme staff may find themselves providing AIDS services rather than drug treatment services. Providing staff with opportunities to form mutual support groups and to vent their feelings and to take a few extra days off are helpful approaches that administrators can take.

Need for More Staff

Given the indications of the seroprevalence studies in various countries, treatment staff can be expected to have increasing numbers of clients who are infected with HIV, or have ARC or AIDS. In addition, agencies should prepare themselves for increased referrals of clients into their treatment programmes as a result of the activities of street workers. Drug treatment staff have performed admirably in meeting the needs of drug abusers, often with limited resources and under stressful conditions. Nevertheless, with the dual diagnosis of both drug abuse and HIV infection or AIDS, drug treatment personnel may be overwhelmed by the new demands on an already overburdened treatment system. National and regional agencies need to consider the need to increase funding to hire additional treatment staff and to serve additional clients entering treatment. Training can have little meaning if staff numbers are inadequate.

Development of training guidelines

The participants formed three separate working groups to discuss training issues and develop recommendations for the three essential phases in the development of training programmes:

— assessment and information gathering

— curriculum development

— implementation and evaluation.

It was recognized that these phases may overlap; each was seen as part of a continuous cycle. For this reason, the report reflects the discussion as a whole, as well as the discussions of each working group.

All working groups based their discussions and recommendations on the following premises.

1. The development of staff training is in the evolutionary stage. Although training is more advanced in some countries than in others, it is still subject to innovation and trial and error.

2. The planning of training programmes within a country needs to involve all levels of government — national, regional and local — as well as private organizations and agencies.

3. Training must be based on the specific needs and cultures of each country. Each country must modify or choose components from the training guidelines given here to create the guidelines best suited to its particular circumstances.

4. Drug treatment staff already possess basic knowledge of chemical dependency, human growth and development, psychology, sociology, and counselling. Educational programmes on AIDS should build on staff's existing knowledge and skills.

5. It is important that organized and systematic plans for AIDS training be developed by national or regional authorities.

6. The training must be continuous and frequently updated, given changes in information on AIDS, the needs of staff, and innovations in the field of drug treatment.

7. AIDS training should be mandatory for all programmes of treatment for chemical dependence, including alcohol programmes and drug programmes that focus on the people who abuse drugs by means other than injection.

Components of a Training Plan

The participants assumed that countries should develop training plans in cooperation with national, regional and local authorities and in consultation with private organizations. Each plan should be flexible enough to meet regional and local needs. Specifics within a training plan should include:

(*a*) needs assessment;

(*b*) the identification of staff in national, regional and local agencies who will be involved in the development of training;

(*c*) the identification of the characteristics of agencies, programmes and individuals that should be targeted for training;

(*d*) the identification of agencies and community organizations that should cooperate in the implementation of training programmes;

(*e*) the listing of resources and support needed to carry out the programme;

(*f*) a discussion of the information, knowledge and skills to be imparted to staff;

(*g*) the specific content of the curriculum;

(*h*) a discussion of educational methods that will best achieve the goals of the training programme;

(*i*) an assessment of the amount of training drug treatment staff need to meet their responsibilities;

(*j*) a discussion of logistical issues such as the selection of trainers, the physical location of programmes and the length and sequence of training courses; and

(*k*) provision for an assessment of the quality, effectiveness and impact of the training programme.

All of these components have been incorporated into the training guidelines that follow.

Assessment of Needs

The development of a systematic training programme must begin with an appropriate and accurate assessment of the need for training. Because of the urgency of the issue, however, a minimal amount of time should be spent on this phase. An estimate must also be made of the prevalence rate of HIV infection among intravenous drug abusers and the number of AIDS cases in this population within the country, along with the areas or regions within which these figures are highest. Other elements of the needs assessment do not have to be rigidly scientific and may include: consultation with known experts on AIDS within the country; discussions with staff of treatment programmes serving populations in which the prevalence of HIV infection and AIDS is high and those in which it is low; discussions with training institutes; a review of the literature and the experiences of other countries; consultation with community AIDS organizations, and with health professionals and other people who provide services to AIDS patients; and a review of existing training materials produced by various organizations both within and outside the country.

Target groups

All drug treatment personnel — counsellors, administrators, physicians and others — should receive AIDS training, regardless of the type of treatment agency within which they work and the prevalence rates of HIV infection and AIDS in the populations they serve.

It is essential that agency administrators allow all staff the time to participate in continuous education programmes. Some administrators think they can fulfil their commitment to training by sending one or two agency staff to AIDS workshops. This is not recommended, since people with HIV infection or AIDS may be referred exclusively to these staff, creating the feeling among other staff members that they are not responsible for such clients and that the trained staff are experts on AIDS.

A continuous theme throughout the meeting was the need to develop links between health and drug treatment services in the community. To strengthen such links, health personnel working with intravenous drug abusers should be targeted for training so that they can gain a better understanding of both the physical and psychological impact of chemical dependency on the individual and family, give better medical treatment to their clients, assess needs for services, and make appropriate referrals to drug treatment programmes.

Two populations growing in importance for training are the people who work in prisons and prisoners themselves. All prison staff should receive regularly updated information on AIDS and other communicable diseases. Prisoners should be given written information on AIDS, and particularly on the risks of homosexual contact and intravenous drug abuse in prison. These facts should be linked with others on communicable diseases and health promotion in general.

In addition, the organizations of homosexuals that have been successful in so many cities in educating the homosexual community on AIDS may be helpful in reaching out to drug addicts with prevention and treatment programmes if the members of the organizations can be educated on the psychological aspects of addiction. Communities may want to explore the extent to which these organizations view themselves as set up to administer to the needs of intravenous drug abusers. Communities should be aware, however, that some drug addicts may not want to be associated with these organizations for fear of being labelled homosexual.

Finally, personnel in agencies providing social services to drug abusers should be educated on AIDS. While the training of these personnel should not be the sole responsibility of the drug treatment authority, authorities should cooperate to avoid duplication of work. In addition, conflicting policies among departments or ministries that may affect training should be identified.

Organization and planning of training

A model for a national training programme, provided by France, the Netherlands and Norway, may help other countries in the organization and planning of training. All three have formed some type of planning or advisory committee on training at the national level. Such a committee can be composed of representatives from the national drug abuse authority, from regional authorities and/or programmes, and from community organizations, as well as experts on AIDS and on curriculum development and training design. Participants at the meeting suggested that one way to foster cooperation between and joint planning by various groups is to hold an initial awareness conference, to stress the value of training to all those targeted and to identify the training needs to which the participants attach the most importance. Concern was also voiced that various interest groups within and outside of government may influence the development of training. It was suggested that these groups should be identified and attempts made to enlist their support or at least to diminish their resistance.

The national drug abuse authority or its delegated representative was seen as the central coordinator or planner of training for many of

the countries. Nevertheless, regional and local involvement in the planning and organization of training was seen as a primary component of a successful training programme. Training should be conducted by the regions with help as needed by the central authority. In the United Kingdom, for example, training is planned and carried out on a regional level. Local and regional authorities and programmes are expected to report on their evaluations of and experiences with training programmes to the central coordinating authority for changes, modifications and additions. No clear arrangement for coordination between regions, however, yet exists.

A national training programme has recently been developed in France. Because it is just beginning, the mechanisms for planning and organization have not been fully tested. The Ministry of Social Affairs and Employment has taken the lead, appointing a national advisory committee to plan a national AIDS training programme. Six regions each selected ten participants to attend a national seminar to consist of three separate training sessions, each lasting three days. The participants are then expected to conduct regional seminars for others, who are then to convey the information to local treatment programmes and projects, which are to report to the national advisory committee to indicate needs for additional training, suggest changes in procedures and make evaluations. The local training courses cover clinical, legal and ethical issues through the presentation of concrete situations that workers must face, employing group discussion and other methods. A training pamphlet and videotape will be developed.

One of the three working groups at the meeting presented the structure of the French national training programme. Within it, the primary role of the national authority is to raise awareness and to be available for consultation with and for supporting regional and local programmes. The regions are to be responsible for the overall administration of local training programmes, including needs assessment, curriculum development and implementation. The regions should also cooperate in the administration of each of these stages. Local programmes should give feedback to both the regional and national levels.

Selection and responsibilities of trainers

The people who actually train drug treatment staff on AIDS could be experts on various aspects of the problem. Such experts, however, may not have the training skills necessary to convey the subject matter to programme personnel. For example, a presentation by a physician, lawyer or researcher may be too technical for the audience.

Effective trainers must know more than their topic; they must understand how to run a group. Expertise is needed in conducting role-playing and small group discussions, teaching people how to deal with their attitudes and those of others, and enhancing skills in other ways. A training team may be the best solution to the problem, with expert trainers used for attitude and skill development and subject experts used to supplement specific technical information where necessary.

An important step in the planning and organization of a training programme is the identification of people with the skills to train others to be trainers. These primary trainers are the most experienced; they will be responsible for instructing the people selected to be trainers at the regional or local level, who in turn will have the major responsibility for training the other personnel of drug treatment programmes.

While the most important qualifications for primary trainers are skills in both training and group dynamics, other desirable qualifications include: expertise in chemical dependency and AIDS; a knowledge of sexuality and sex education; a basic knowledge of human behaviour and development; feelings of ease in conveying information of a sensitive nature; an acceptance of different lifestyles and value systems; and a lack of excessive anxiety about AIDS transmission and other AIDS issues. The last four qualifications are essential for a skilled trainer. It is highly desirable to find people with expertise in chemical dependency, sex education and AIDS, but this may be difficult. Therefore, a training team may be composed of individuals with varied knowledge and skills.

Trainers at the local or regional level should fill two major roles: to conduct formal training programmes at local level, and to be liaison people within their local treatment agencies, responsible for identifying relevant literature and materials about AIDS and giving information to others within the agency, individuals at regional and national levels, and the community. The major qualification for this position is an interest in AIDS and the willingness and ability to take on this responsibility.

The criteria for selecting people to conduct formal training programmes on the local level should include the qualifications listed previously for primary trainers. It is important that those on the national or regional level determine the qualifications required and the duties of the staff who are to be trained as trainers, to guide directors of the regional and local programmes in selecting the staff who will attend the course. These potential trainers should possess some basic training skills or exhibit the ability to develop them quickly. If these skills are lacking, staff at the national level should be

expected to include them in the content of the courses. As in the case of primary trainers, local training teams of people with different knowledge and skills may be developed. Regional or national drug treatment authorities must be prepared to monitor and assist local trainers, to help them to sharpen and refine their skills and to present them with new information.

In the United States problems arose because some of the people selected as potential trainers lacked basic training skills and the course set up to train them was based on the assumption that the participants would have such skills. In addition potential trainers needed to be given the time by their agencies to train others in their locale. Because the amount of time to be devoted to training others was not specified, some directors of local treatment programmes were hesitant to provide this release time.

Another approach to training may be taken: experts from training institutes can conduct all training programmes. Although this approach may appear to be easier, it precludes local involvement and the ripple effect, in which primary trainers instruct others, who can in turn train drug treatment staff and eventually conduct their own training of trainers courses. The national drug abuse agency may want to evaluate the relative cost of each approach.

Curriculum Development

The curriculum of an AIDS training course should have three interconnected and interactive parts:

- facts (information on such topics as the transmission of HIV and other medical issues, and risk reduction measures);
- attitudes (including work with staff to relieve their fears about AIDS, to examine their attitudes towards sexuality and to encourage the commitment to intervene in the epidemic, the belief in the ability of people at risk to change, nonjudgemental attitudes towards drug abuse and sexual practices and sensitivity to cultural differences); and
- the development of skills (such as the ability to impart specific knowledge about AIDS to clients, to counsel them on ways to reduce their risk — through using clean needles and safe sexual practices — and on other issues, such as death and dying).

Most training courses should include all three elements. The ultimate goal is for clients to change their behaviour. It was recognized that the content of training should include prevention and

treatment skills. All courses should instil in the participants sensitivity to and knowledge of the cultural and ethnic values of minority groups.

Course content

It is most important that *agency administrators* receive AIDS training, so that they have the information and skills necessary to make the difficult decisions related to AIDS in their agencies, to supervise staff appropriately, and to contribute to policy development. It is suggested that administrators be trained before their staff, to ensure that they gain a complete understanding of the issues and to secure their full support for staff training. In addition to their own courses, administrators should be familiar with the content of those for counsellors.

In the United States a two-day course was developed for administrators, conducted with a maximum of 30 participants and using didactic presentations followed by small group discussions.[a] Because administrators were felt to be resistant to addressing their own emotions in such a course, the information is presented in a more formal and conventional way. The training programme focuses on the AIDS-related issues that an administrator may confront in the daily routine of managing a treatment agency. It is assumed that administrators already have basic management skills.The course includes such subjects as:

(*a*) facts on AIDS;

(*b*) dealing with staff issues such as burnout and the fear of contracting AIDS;

(*c*) hygienic concerns about agency facilities;

(*d*) policies on testing for HIV antibody;

(*e*) legal and ethical issues;

(*f*) developing prevention and education strategies suited to the circumstances of each programme;

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[a] Training manuals have been produced in the United States by the National Institute on Drug Abuse: *AIDS and the IV drug abuser: a training program in administrative planning for outpatient clinic directors* and *AIDS and the IV drug user: a training program in education, risk assessment and treatment planning for drug abuse program counselors* (Rockville, MD, National Institute on Drug Abuse, 1987).

(*g*) examination of the delivery of treatment services within the agency (including changes in service delivery, case management and techniques and styles of counselling, additional duties and responsibilities of staff, and admission and discharge policies);

(*h*) developing links with other community services to which clients can be referred;

(*i*) political and public relations issues in dealing with decision-makers and the community at large; and

(*j*) cooperation with other administrators in dealing with the mass media and finding increased funding.

In the final part of the course, administrators are expected to assess the AIDS programmes of their agencies and to develop six-month action plans for these programmes.

The content of courses for drug treatment *counsellors* will differ from that for administrators. Staff require training in 11 different areas to carry out their responsibilities to clients with HIV infection or AIDS. The content suggested for each area can be delivered alone or in combination with that of other areas.

1. *Basic medical and scientific knowledge of AIDS.* This information should cover such topics as HIV transmission, the symptoms of HIV, ARC and AIDS, medical treatments, perinatal transmission and neuropsychological complications (including HIV dementia). Basic information on AIDS virology and immunology should also be included.

2. *Psychological barriers to delivering effective treatment.* Instruction in this area should cover staff's feelings, including anxiety about contracting AIDS, and feelings about delivering treatment to someone with HIV infection, ARC or AIDS and about discussing sensitive topics such as sexuality, dying and death. Staff must also learn to deal with the anxieties and misconceptions that clients have about HIV infection and AIDS. Trainers need to help staff to accept their limitations, to allow them to vent their feelings on a personal as well as a professional level and to deal with the resentment of new additions to an already excessive burden of responsibility.

3. *Testing for HIV antibody.* Staff need to provide accurate information and supportive counselling on HIV antibody testing. To do so they need to know the facts about antibody testing and to identify the psychosocial issues that testing raises in a client. Staff also need to be familiar with the issues of confidentiality surrounding testing.

4. *Prevention.* Counselling on AIDS prevention should be aimed at all intravenous drug abusers regardless of whether they are infected with HIV and whether they are receiving treatment. The counselling should include instructions on cleaning needles, how to inject properly, how to use a condom, and other issues of sexuality. Counsellors should also urge clients to develop a healthier lifestyle through such measures as a nutritious diet and the reduction of stress. Preventive efforts should take place both in treatment agencies and on the streets, but addicts should be encouraged to undergo treatment.

5. *Outreach.* Although it is desirable to hire street workers to take the major responsibility for outreach, agency personnel may have to do this work themselves. As part of the prevention programme, street work should include efforts to help hard-to-reach groups, which include intravenous drug abusers (including prostitutes) not in treatment, their sexual partners (who perhaps do not abuse drugs), and people under arrest or on parole or probation who are identified as intravenous drug abusers and/or have been involved in drug-related criminal acts. Special attention needs to be given to members of minorities, particularly when cultural and language differences are apparent. Although all these groups should receive messages similar to those given to addicts receiving treatment, the groups are difficult to reach through traditional forms of health education. Treatment staff may need to discover the relative effectiveness of various outreach strategies, to develop innovative strategies and to identify sources of help in the community.

Some issues for outreach include: providing appropriate prevention and education messages and means of delivering them to different target groups; delivering messages in a street setting; identifying the social networks of intravenous drug abusers and places where they congregate; contacting and communicating with these people, their associates and neighbourhood residents; learning how to become accepted by all these groups; providing a range of viable alternatives to intravenous drug abuse; encouraging the adoption of risk reduction measures; and linking and setting up referral networks between hospital emergency rooms, health care facilities, social service agencies and criminal justice institutions.

6. *Sexuality.* Courses on sexuality should both sensitize staff to their own feelings about sexuality and teach them skills to discuss issues such as condom usage and safer sexual practices with their clients. Courses should also cover the effects of substance abuse on sexual behaviour, male and female prostitution, bisexuality and

homosexuality (particularly the special needs of the homosexual or bisexual intravenous drug abuser), and counselling on pregnancy and abortion.

7. *Women at risk.* The needs of women who abuse drugs by injection and those at risk of HIV infection from sexual partners who abuse drugs by injection differ from those of men in the same circumstances; this necessitates different approaches to prevention and risk reduction. Women at risk have special problems related to sexuality, family planning, partnership dynamics and self-esteem. Special skills should be taught, through assertiveness training for example, to help them get their partners to practise safe sex. Delivering counselling and support services to certain groups of women, such as prostitutes and women with HIV-infected children, may also require special strategies.

8. *Family counselling.* HIV infection or AIDS in one member affects the whole family. It is important to involve the family (parents, siblings, children and other relations, and friends) in the treatment and support of the HIV-infected drug abuser. Although this may be difficult, since these families are often unstable, it is important that, whenever possible, the family be encouraged to take part. Staff will need skills in confronting a family's desire to resist and deny the problem, informing them about AIDS and HIV infection, and helping them to prepare for the death of a loved one and the grief that follows. Staff will need knowledge of elementary family systems theory, particularly as it applies to chemically dependent members of families.

9. *Death and dying.* These are sensitive, personal issues, which may not be openly discussed in some societies. Drug treatment staff must first confront their own feelings on the issue. The thinking of experts such as Kubler-Ross can be helpful as a model for a course on this topic. Feelings that clients have never explored may need to be addressed in counselling, even though counsellors may be hesitant to tap them. Counsellors need to help clients deal with all of their emotions, including grief. Staff should also be aware of their own bereavement overload, the accumulation of grief; if not relieved, this can affect their working and personal lives.

10. *Support groups.* In a research study,[a] Des Jarlais found that the strongest determinant of addicts' use of risk reduction measures is

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[a] **Des Jarlais, D.C.** Stages in the response of the drug abuse treatment system to the AIDS epidemic in New York City. *Journal of drug issues* (in press).

the practice of such measures by their friends. Peer support groups may thus help addicts to change their lifestyles. The use of peer support is a hallmark of therapeutic communities. Staff using other approaches to treatment must learn how to develop support groups, recruit members, set guidelines and lead or assist a group, particularly when sensitive topics may arise. Groups for drug abusers (for support, education, counselling and psychotherapy) and for family members of people with HIV or AIDS may need to be developed.

Staff whose clients have HIV, ARC or AIDS also need continuing support. The members of local training groups, continuing to meet regularly over a prolonged period, could both give mutual support and identify new training needs to be met in future training programmes.

11. *Legal and confidentiality issues.* Drug treatment workers should be familiar with the laws of their countries on confidentiality. They should be up to date on the thorny legal issues surrounding the AIDS epidemic. For example, should health personnel disclose information on people with HIV or AIDS? They may be held legally liable if they do not. Other issues include the duty to report cases of HIV infection and AIDS, laws against discrimination, and social services entitlements. They should also be aware of relevant legislative proposals and recent court decisions. Although these issues may directly affect the functioning of staff in drug treatment programmes, the relevant laws in many countries are only in the formulation stage.

Training design and methods

Once the content of the course has been determined, a training design should be developed. It should include not only the objectives of the course (what the worker is expected to learn) but also how the worker will learn (the specific methods to be used), the time that will be needed to meet the training objectives, the sequence of courses and the topics and information within them, and the materials and equipment needed for the training. Training designs should be developed for the training plan as a whole and for each course.

Course materials can be written by experts in the field, although staff knowledgeable in curriculum development should actually design the course, setting a sequence for the use of materials and developing a time frame, the methods and the objectives for the course. A distinction should be made between trainers and curriculum developers. Each group may lack the skills appropriate to the other.

Including a variety of activities in a course broadens learning and makes training more interesting. As staff learn new skills, they need

the opportunity to practise these skills. Different types of learning activities are suggested which include: guided group discussions, group problem-solving exercises, role-playing and psychodrama, written and nonverbal exercises, videotapes to trigger further discussion, brainstorming, process analysis and demonstrations.

An outline or detailed curriculum?

A major issue is whether to develop detailed or outline curricula. Although a detailed curriculum coming from the national or regional level may not meet all the needs of local treatment staff, it ensures some standardization of training and quality control. On the other hand, a curriculum guide or outline may be too flexible and vulnerable to the idiosyncrasies of the trainer. An outline format also makes it more difficult to monitor the quality of training and to ensure that all important points have been covered in a training session.

To limit the cost of developing a training curricula and accompanying materials and help avoid duplication of work, it is suggested that the national drug abuse agency, in cooperation with regional and local drug treatment programmes, take the lead in developing a curriculum and materials that spell out the most important elements but are flexible enough to allow modification at the local level. If it is not possible to develop a fully detailed curriculum, the outline should be as specific as possible, with simple instructions for trainers on the methods to be used, the time allowed, the objectives and the subject matter of the training.

The National Institute on Drug Abuse in the United States developed a detailed curriculum in cooperation with the individual states. It allows each state to make revisions appropriate to its unique situation. This curriculum was pilot-tested before being made available for use. This basic curriculum saved each state the cost of developing its own materials and of duplicating work.

Pilot tests should be made on all training materials, using samples of drug treatment staff, before a training curriculum is offered to regional and local programmes. In some instances two or three pilot tests, followed by revisions, may be needed before the course is deemed satisfactory. Information may need to be clarified, and materials, the sequence and methods of delivery and the amounts of time spent on particular topics may need to be changed.

Implementation and Evaluation

Time

A major issue is the length of training, since staff have difficulties in obtaining the time to take courses. The training in a national

programme developed in France takes place over the course of a year. In the Netherlands, in-service training has been conducted within drug treatment agencies; this may be a way of avoiding the issue of release time for staff. In Norway, intensive training seminars have been for groups of up to 60 people gathered at a hotel; the seminars last three days, and instruction continues into the evenings. In addition, a series of one-day conferences for primary trainers is planned.

Decisions on the length of training will depend on the needs of local staff. One suggestion is a basic, mandatory overview course for all staff, covering the most important issues in three days. This basic course could be offered several times within a six-month period so that administrators could avoid stripping their centres of staff for three days. After the basic overview, a "cafeteria approach" could be used, with staff selecting in-depth courses dealing with the topics most relevant to their work. This second round of courses can be given on several consecutive days or in discrete segments that span a particular time period (for example, two hours per week for three weeks).

Techniques of implementation and evaluation

The use of videotapes (particularly trigger videos, which present various situations appropriate for group discussion) was seen as effective. In Norway a professional theatre group is to be set up, to go to hospitals, other treatment institutions and prisons to perform a play about drug abusers and the problems of the HIV epidemic. The actors will also be used in training staff members. The role of staff in treatment programmes will be part of the play. After each performance there will be a discussion, during which the actors will maintain their roles. In France a videotape presentation is planned, focusing on seriously ill patients and the anxiety of drug treatment personnel.

No country has considered the use of teleconferencing or interactive videodiscs. The participants at the meeting felt that the most important component of training is the building of skills through practice and the interaction between the participants and between the trainer and participants. It was felt that this interaction could not be duplicated through technology.

The United States is planning a series of instructional videotapes for staff; these can be incorporated into a training programme or shown independently. Videotapes on AIDS prevention will also be developed for clients. The use of teleconferences as a training mechanism is being explored. The use of these technologies for AIDS training programmes is to be evaluated.

Once a training programme is in operation, it should be continuously evaluated. Evaluation forms should make it easy for staff to give full and accurate answers. A variety of question forms should be used; a simple Likert scale, true/false and multiple choice questions, and queries eliciting subjective comments are appropriate. Evaluation may take place at several levels.

First, measuring the knowledge, skills and attitudes acquired during the training requires that participants be tested immediately before and after the course, to determine whether the objectives were met. Feedback can also be obtained on the training itself: the methods, techniques and materials used, the skills of the trainer and other experts conducting the course, the length of the total programme and the time spent on each topic within the course, and the quality of the facilities in which the programme was conducted.

Another evaluation should take place two to six months after the training to determine whether staff are actually using their newly acquired knowledge and skills. This evaluation can pinpoint areas that are causing staff difficulty and may thus require review or indicate additional areas for training.

The training of trainers should also be evaluated. Attention might focus on: the number of training programmes conducted, problems that arose, the response of participants, trainers' modifications of the programme, and the need for assistance in the planning and/or delivery of training.

Finally, because the ultimate goal of training is to change clients' lifestyles, reduce risk behaviour and decrease HIV infection among drug addicts, it is important to determine whether these changes actually occur and which techniques are the most successful in bringing them about. The effect on the client is difficult to evaluate and may be confounded by additional variables, such as the fact that addicts may have been infected before the implementation of the training programme, policies on needle exchange, the accessibility of health services, and the effects of mass media presentations. It may never be possible to prove scientifically that training causes an overall reduction in risk behaviour and HIV infection in intravenous drug abusers, although overall seroprevalence rates within a particular area may be measured before and after the initiation of prevention and treatment programmes. Surveys in which addicts are asked directly about behaviour change, such as the one conducted by Des Jarlais in New York City, have been helpful in providing staff with feedback on useful techniques and approaches.

Conclusion

This report offers basic guidelines for countries to use in developing AIDS training for the staff of drug treatment programmes who face a difficult task. To accomplish it, staff are learning how to deal with AIDS as a part of their work. The guidelines presented in this report represent solid building blocks for successful training programmes. As countries plan, develop and run their training programmes, they will find new ideas to meet the needs of treatment personnel and their clients. Some models may be more successful than others and unexpected challenges will arise. Countries should therefore continue to exchange information and to work together towards the ultimate goal of preventing the spread of AIDS. The World Health Organization's Regional Office for Europe could perhaps facilitate the regular exchange of experiences, training modules and curricula.

Annex 1

Participants

Austria

Professor A. Springer, Leiter, Ludwig Boltzmann-Institut für Suchtforschung, Vienna

Belgium

Ms M.-C. Piron, Cabinet du ministre de la santé de la communauté française, Brussels

Denmark

Ms M. Posborg, Copenhagen Municipal Treatment Institute for Substance Abusers

France

Dr N. Jeanfrançois, Direction générale de la santé, Ministère des affaires sociales et de l'emploi, Paris

Professor A. Sobel, Hôpital Henri Mondor, Créteil

Federal Republic of Germany

Ms E. Koller, Drogenbeauftragter des Landes Berlin, Berlin (West)

Professor H. Rasche, Klinik für Innere Medizin, Zentralkrankenhaus St-Jürgen-Straße, Kliniken der Freien Hansestadt Bremen

Professor P. Schönhöfer, Institut für Klinische Pharmakologie, Zentralkrankenhaus St-Jürgen-Straße, Bremen (*Chairman*)

Mr E. Speidel, Gesamtverband für Suchtkrankenhilfe, Kassel

Greece
Mrs I. Koukiou, Ithaki Therapeutic Community, Salonica

Israel
Dr M. Reiter, Director, Tel Aviv-Jaffa Drug Abuse Rehabilitation Centre, Tel Aviv

Italy
Dr G. Rezza, Directorate-General of Social Medicine, Ministry of Health, Rome

Netherlands
Dr E. Stijntjes, Federation for Alcohol and Drugs, Utrecht

Norway
Ms A.-L. Middelthon, National Narcotics Advisory Board, Oslo

Poland
Professor A. Stapiński, Head, Clinic for Venereal Diseases, Warsaw

Portugal
Dr T. Nunes Vicente, Rua de Alcolena, Lisbon

Spain
Dr M. Diez Ruiz-Navarro, Regional Plan on Addictive Drugs, Autonomous Community of Madrid

Sweden
Dr G. Dahlström, Executive Director, Vallmotorp Foundation, Julita

Mr D. Kisro, Vallmotorp Treatment Centre, Katrineholm

Switzerland
Dr W. Fuchs, Beratungsstelle, Sozialpsychiatrischer Dienst, Psychiatrische Universitätsklinik, Zurich

United Kingdom
Mr A. Parry, Mersey Regional Drugs Information Centre, Liverpool

Yugoslavia
Dr D. Nikolić, Federal Institute of Public Health, Belgrade

Temporary advisers

Dr R. Ashery, Community Research Branch, Division of Clinical Research, National Institute on Drug Abuse, Rockville, MD, USA (*Rapporteur*)

Dr J.B. Brunet, Institut de médecine et d'épidémiologie africaines et tropicales, Hôpital Claude Bernard, Paris, France

Dr D. Des Jarlais, Coordinator for AIDS Research, State of New York, Division of Substance Abuse Services, New York, NY, USA

Dr E. Sandström, Department of Dermatology, Södersjukhuset, Stockholm, Sweden

Mr D. Turner, Standing Conference on Drug Abuse, London, United Kingdom

Observers

Mr T. Pörksen, Der Senator für Jugend und Soziales, Freie Hansestadt Bremen, Federal Republic of Germany

Dr N. Schmacke, Hauptgesundheitsamt, Freie Hansestadt Bremen, Federal Republic of Germany

Dr G. Schöfer, Der Senator für Gesundheit und Sport, Freie Hansestadt Bremen, Federal Republic of Germany

Dr H. von Schwarzkopf, Hauptgesundheitsamt, Freie Hansestadt Bremen, Federal Republic of Germany

WHO Regional Office for Europe

Mr C. Goos, Scientist, Abuse of Psychoactive Drugs

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AIDS has become a bitter fact of life in the modern world. Help is needed from people in all sectors of society in work to limit the spread of the disease and the toll it takes of human life. In particular, AIDS is beginning to make increasing demands on workers struggling with another problem of modern life: intravenous drug abuse. These people are already overburdened. How are they to meet the additional and growing challenge of AIDS among drug addicts?

This was the question addressed by the participants at a recent WHO meeting. This book is their answer. To cope with the burden of HIV infection and AIDS in their clients, all drug treatment staff need new facts and skills; these can be acquired through carefully planned training programmes. This report offers basic guidelines for countries to use to develop training programmes that meet their particular circumstances. Specific suggestions are made about the needs of different target groups, the goals of training, and the curricula, methods and timing of courses. Training is essential, the experts argue, if drug treatment staff are to help their clients to change their behaviour, not only to break free of chemical dependence but also to avoid contracting or spreading HIV infection.

The training guidelines presented here are solid building blocks for successful AIDS training programmes in the countries of Europe. This report offers valuable reading for everyone interested in the interlocking problems of chemical dependence and AIDS, and in what drug treatment staff can do to meet this combined threat to health for all.

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